Illinois HIV Integrated Planning Council (IHIPC) Webinar Minutes
August 17, 2018, 9:30 am – 12:30 pm

9:30 am: Welcome; Introductions; Moment of Silence

The Co-chair, J. Nuss, welcomed all participants to the meeting. She introduced the Community Co-chair, M. Benner; the webinar facilitator, B. Walsh; and the meeting presenters. J. Nuss led the group in a moment of silence for all people living with HIV past and present as well as for all those working to end HIV in Illinois.

9:35 am: Meeting Process/Instructions

» Meeting process, meeting survey, online discussion board instructions

J. Nuss noted that now that we have a newly-seletced Community Co-chair, he will be taking on a large role in co-facilitating our meetings. But the Co-chair informed her this morning that due to a bad cold that has affected his voice, although he is participating in the webinar, will not be speaking today.

J. Nuss reviewed the webinar/ remote participation instructions with participants. It was noted that the meeting was being live-streamed as well as recorded. It was also noted that several participants had come into the meeting as "call users", which meant that they may have been participating by phone only without signing into the webinar itself. It was announced that those users' attendance cannot be tracked and that they should contact J. Nuss to report their presence at the meeting. Call in features, the chat box feature, and the "raise hand feature" were reviewed with participants.

Links for the meeting documents and meeting survey were shared with participants. Meeting surveys will also be emailed to registered participants after the meeting. J. Nuss asked that all meeting surveys be completed by August 24th. The recorded webinar will be available on the TRAIN Illinois website 1-3 days after the meeting, and the link will be sent to participants by email when it is available.

» Roll call attendance of voting members, announcement of non-voting members and others, including those participating remotely

J. Nuss thanked everyone for their patience with the new WebEx system. Due to difficulties in muting ans unmuting attendees, the meeting proceeded without a formal roll call, but members were assured that attendance of all participants would be tracked and recorded through the WebEx system.

» Review of agenda, meeting objectives, IHIPC purpose,

The agenda and meeting objectives, which were directly related to information sharing, discussion, and providing input on the presentation topics, were reviewed. It was noted that the format of the agenda has been simplified, but still indicates how each presentation is related to the National HIV/AID Strategy (NHAS) and steps of the Care Continuum. The primary goal of the IHIPC and its relationship to NHAS was reviewed. The current stakeholder engagement list, which shows that 56 new community stakeholder have been engaged in IHIPC meetings thus far in 2018, was also presented.

» Announcements, Updates

J. Nuss noted that results from the June 28th IHIPC meeting Recap Activity (identifying factors that most influence HIV acquisition or transmission) had been compiled and recorded. A follow up recap activity, utilizing those results, will be conducted at the October meetings. Membership updates were announced: R. Patterson from IL State Board of Education has retired as of July 31, and his seat on the IHIPC is vacant at this time; and T. Markovich, an elected voted member, has taken a new job in Missouri and has therefore stepped down from her position. This means that in the upcoming membership selection process, one person will be selected as a new voting member and up to six people will be selected as at-large members. The Steering Committee

is discussing options for replacing the appointed position vacated by R. Patterson. J. Nuss reminded participants that the IHIPC is accepting new applications for membership through September 15. As discussed at the June meetings, the IHIPC priorities for membership gaps are: individuals from Regions 1 and 2; Individuals from the transgender community; Individuals of Black, Hispanic, or "Other" race; and Black or Hispanic MSM. J. Nuss reminded all members that the "High Impact Prevention Strategies and Interventions for 2019" training must be completed by members August 31 if not completed already. The training registration link was shared with all participants.

J. Nuss reminded participants that work is still being done to transition the IHIPC website to the IDPH webpage. Materials for meetings (including committee meetings) January- June can be found at the ihipc.org site, and material published in July and beyond can be found on the IDPH IHIPC webpage. It was announced that the next in-person IHIPC meeting will be held October 29th and 30th in Springfield. Members will soon be contacted by email to confirm attendance and lodging needs. Announcements with details about the meeting for community members will be forth coming. It was also announced that the Fall IHIPC newsletter was being finalized and that articles are now being accepted for the Winter newsletter. Members and participants were encouraged to submit relevant article and information by November 16. Lastly, J. Nuss reviewed the IHIPC Concurrence Checklist and encouraged members to review it thoroughly in order to ensure that the IHIPC is meeting its goals and purposes.

9:45 am: 2019 Prevention Grant Workplan and Budget: Demonstration of Linkage to Integrated Plan Priorities/ 2019 Prevention Services Regional Gap Analysis: Funding and Service Distribution/ Q&A, Discussion, Input

Curt Hicks, IDPH HIV Prevention Administrator

**NHAS Goal 1, Goal 2, Goal 3, Goal 4; Steps of the HIV Care Continuum: All*

C. Hicks presented 2019 Prevention Grant Workplan and Budget and its linkage to the Integrated Plan as well as the 2019 Prevention Services Regional Gap Analysis. The presentations were reviewed one after another, and one Question and Answer period was taken for both presentations.

C. Hicks began the presentation by reviewing components of IDPH's 2019 HIV Surveillance and Prevention application for the Centers for Disease and Prevention Control's PS18-1802 grant. The priorities of the grants were reviewed and included the following: 1. Increase individual knowledge of HIV status; 2. Prevent new infections among HIV- negative persons; 3. Reduce transmission from persons living with HIV; and 4. Strengthen interventional surveillance to enhance response capacity and intensive data- to- care activities to support sustained viral suppression.

The budget for PS18-1802 was reviewed. Overall, budget amounts from 2018 to 2019 remained the same. Participants were reminded that federal funding cannot be used for syringes or other harm reduction supplies; for medical services (although PrEP financing and grants are supported through other IDPH endeavors); and no more than 5% of federal funding can be used for integrated services such as STD & Hepatitis testing and vaccinations. A detailed list of allocations was included in the presentation. Additionally, it was noted that many perinatal activities are now being financially supported by Ryan White Care dollars.

The following strategies for PS18-1802 and their outcomes were reviewed in detail during the presentation:

1. Systematically collect, analyze, interpret, and disseminate HIV data to characterize trends in HIV infection, detect active HIV transmission, implement public health interventions, and evaluate public health response.
2. Identify persons with HIV infection and uninfected persons at risk for HIV infection.
3. Develop, maintain, and implement a plan to respond to HIV transmission clusters and outbreaks.
4. Provide comprehensive HIV-related prevention services for persons living with diagnosed HIV infection.
5. Provide comprehensive HIV-related prevention services for HIV-negative persons at risk for HIV infections.
6. Conduct perinatal HIV prevention and surveillance activities.
7. Conduct community-level HIV prevention activities.
8. Develop partnerships to conduct integrated HIV prevention and care planning.
9. Implement structural strategies to support and facilitate HIV surveillance and prevention.
10. Conduct data-driven planning, monitoring, and evaluation to continuously improve HIV surveillance, prevention and care activities:
    - It was explicitly noted that this work should continue to focus on disparities of HIV among Black and Hispanic MSM. Although gaps in service are continually decreasing, racism and homophobia continue to perpetuate long standing trends of underservice to these

populations, which account for nearly half of new infections each year. This strategy serves to continue specific capacity building and peer recruitment activities that aim to adequately serve Black and Hispanic MSM.

11. Build capacity for conducting effective HIV program activities, epidemiological science, and geocoding.

C. Hicks then reviewed the 2019 Interventions and Services proposed in PS18-1802. Changes from 2018 that will remain in 2019 were highlighted in red in the presentation. New 2019 changes were highlighted in purple:

- Comprehensive Prevention for Positives: 2019 updates include adding intervention such as Testing Together & HIV Navigation Services; and conducting new Surveillance-Based Referrals that included information about clusters and unsuppressed viral loads.
- Program Coordination and Service Integration: 2019 updates include adding extragential gonorrhea and chlamydia screening.
- Evidenced-Based Interventions for highest risk HIV-negative people: 2019 updates include removing Internet Risk Reduction Counseling and adding HIV Navigation Services for HIV-negatives to the approved interventions list.
- Policy initiative: 2019 updates include introducing HIV outbreak & cluster detection and response protocols; training providers in insurance reimbursements for integrated testing, evidence-based interventions, PrEP, & PEP; and establishing automatic electronic cross-jurisdiction partner services referrals.

To conclude the Workplan and Budget presentation, C. Hicks demonstrated how the PS18-1802 application aligns with NHAS and therefore aligns with the Illinois HIV Integrated Plan.

C. Hicks then continued with the 2019 HIV Prevention Regional Gap Analysis presentation. First, the budget for the Regional Implementation Grants (RIG) was reviewed. It was noted that the overall funding amount from 2018 to 2019 remained the same ($1 million in federal funds and $4 million in state funding). The funding awards are distributed as follows: 2 percent of the total funding is split equally among the 8 Regional Lead agents for administrative duties (reporting, etc.); 13 percent of the total award is split among lead agents for other administrative duties on a sliding scale to account for more work in larger regions (more billing, site visits, capacity building, etc.). The remaining 85 percent of funding is distributed for programming costs among the regions according to HIV epidemiologic proportion (2/3 HIV incidence and 1/3 HIV prevalence). Specific award amounts by Lead Agent/Program award categories were included in the presentation.

The presentation continued by explaining the purpose of the RIG grants, which is to fill in gaps in service that are not fulfilled by other state grants (African American AIDS Response Act, Quality of Life, Direct Grant, etc.). Each region's HIV incidence share by prioritized population (16 categories by transmission category/ race) is therefore compared to services rendered to each prioritized population by other state grants. Any identified gaps per prioritized population are determined to be scopes in the RIG grants. It was noted that the gap analysis is conducted by reviewing the past 5 years of reported regional incidence (2012-2016) and other grant service delivery (which includes recently discontinued grants such as DASA and Category C). Results of the statewide gap analysis were presented, with emphasis on filling regional gaps for Black and Hispanic MSM. It was noted that although some prioritized populations have 0% scopes in the RIG grants as they are covered by other grants, RIG providers can still test/ provide services for any person through supplemental services.

Q& A:

- Q: J. Peller asked: Do the cases of Illinois diagnoses by race and risk include Chicago?
- A: C. Hicks responded: Chicago data is not included in these presentations because Chicago gets its own federal funding to provide their HIV prevention services in the city. Our funding, in particular the regional grant funding, is for outside of the city of Chicago.
- Q: J. Dispenza asked: Great presentation. You said perinatal activities are now conducted by Ryan White, but we saw perinatal information in prevention strategies and for IDPH staff expenses. Can you please clarify this?
- A: C. Hicks responded: Perinatal has changed in terms of funding streams as most activities are Prevention for Positive services/ treatment related. The IDPH Prevention Unit will continue to have a Perinatal Coordinator, but Ryan White will pick up costs like FMIR reviews, pediatric HIV reporting, and monitoring of perinatal testing. This shift in funding also requires a shift to HRSA standards (which have been previously addressed through perinatal case management). The Perinatal Coordinator in Prevention will now be cross trained in both Prevention and Care components. Ultimately, the funding stream will change, but activities will stay in Prevention.

- Q: D. Hunt asked: In regards to data sharing, do strategies include making data more accessible to regions, including viral load data?
- A: C. Hicks responded: This varies from project to project, but IDPH can share viral load information with local health departments and designated community-based organizations that are doing surveillance-based services. About one year ago, a clause was added to the testing consent form that allows IDPH to release information to testing providers if there is evidence of past care or past diagnosis. This allows for the provider to collect feedback about re-diagnosis and barriers that led the client to previously fall out of care. This sharing is not built into Provide™ yet, and this and other projects cannot be completed at this time due to contract issues. It is, however, a plan for the future.
- Q: D. Hunt asked: Will gap analysis data be available by region?
- A: C. Hicks responded: Yes, please send an email to curt.hicks@illinois.gov to request this. C. Hicks can also assist with technical reviews of said data.
- Q: C. Wade asked: I want to commend the IHIPC on the planning process and recognizing the need for MSM engagement. I also want to impress upon IHIPC presenters to be aware of using unintentionally stigmatizing language in presentations and discussions. How will IDPH engage people living with HIV in addressing strategies and interventions, especially for surveillance based services, due to privacy concerns that are highlighted across the nation?
- A: C. Hicks responded: One forum that is available to address and discuss this important issue of privacy concerns for people living with HIV is the IHIPC LTC RCC ART VS Committee, which specifically focuses on Prevention for Positive strategies. Please join the committee calls or ask for time on the agenda to discuss specific topics. If community input is needed, topics could be incorporated into activities like focus groups for sharing information and concerns. It is beneficial to hear this type of input to allow for inclusive, thoughtful planning.
- Q: C. Wade commented: Risk based strategies alone seem to be challenging with under reporting of risk from client and provider limitations in ascertaining risk factor information.
- A: C. Hicks responded: C. Hicks agreed that this has been a concern since the beginning of the HIV epidemic. Successfulness of risk-based strategies can depend on staff experience and their ability to engage clients for risk disclosure. We are continually working to engage clients with behavioral and biomedical strategies together for effectiveness. It is also important to remember that disclosures are not only important to address HIV, but also other health concerns such as HCV, STDs, etc. Ultimately, we have to offer services that help people feel safe and not judged. Sometimes, the best thing that a provider can do is to offer tools and encourage people to use them if they are interested. Our providers are committed and do a great job working with clients, but we can always try to improve in this aspect so that clients can protect their health and the health of their partners.
- C: C. Wade commented: Please do not lose sight of using words that could be stigmatizing to clients in documents and presentations, i.e. "infections" or infectious.

11:00 am: Results of 2018 Ryan White Part B Client Satisfaction Survey/Q&A, Discussion, Input

Bryan Walsh, IDPH HIV RW IT Administrator.

**NHAS Goal 1, Goal 2, Goal 3, Goal 4, Steps of the HIV Care Continuum: All*

B. Walsh presented the statewide results of the 2018 Ryan White Part B Client Satisfaction Survey. He began the presentation by noting that all Regional Lead Agencies have received their respective reports, including comments, before today's meeting.

It was reported that overall 487 clients completed the 2018 survey. The participants' demographic information was reviewed by region, gender (majority: men), age (majority: 45 years of age and older), race (majority: White or Caucasian), ethnicity (majority: Non-Hispanic), current living situation (majority: rent or own a home or apartment), time since diagnosis (majority: 10 years ago or more), and HIV risk factor (majority: sex with male). Yearly trends from 2015-2018 in most demographic categories were reported during the presentation. It was noted that because of technical issues that could not be identified or resolved by IDPH staff or the Survey Provider, the demographic information for 50 surveys was not recorded and therefore cannot be reported.

Results from survey questions about the following Core Services (which are included on all annual Client Satisfaction Surveys) were presented. Trend data from 2015-2018 was also available for these results:

- Case management: Of clients who are case-managed, almost all participants saw their case manager at least once a year. Overall, clients were satisfied with case management and thought that seeing a case manager helped them to stay in care.

- Outpatient/Ambulatory Care: The majority (83 percent) of survey participants had seen their physician within the last six months. Overall, clients were satisfied with outpatient/ ambulatory care services.
- Medication Assistance Program: Overall, clients were satisfied with the Medication Assistance Program (ADAP). Some client reported having trouble with the Program's contracted pharmacy, but new procedures for enrollment between the pharmacy and the Program may have cause increased satisfaction compared to 2017.
- Dental: Overall, clients were satisfied with dental services. Satisfaction with dental services increased from 2017.

Results from survey questions about the follow Supportive Services (which are rotated on a bi-annual basis) were also presented:

- Mental Health: Overall, clients were extremely satisfied with mental health services (as it had the best satisfaction scores of all services). Satisfaction with mental health services increased from 2016.
- Medical Transportation: Compared to other service categories, client were less satisfied with transportation services. Medical Transportation scores decreased significantly compared to 2016.

Additionally, survey participants were asked about their knowledge of PrEP. Approximately 18 percent of participants reported not being aware of PrEP, while other participants had some or extensive knowledge of PrEP. Trend charts regarding PrEP knowledge show that PrEP knowledge among participants has been steadily increasing since 2015. Clients were also asked if they had received information about the following prevention-based services from their case managers: partner notification/ testing, accessing free condoms, accessing free syringes, HIV prevention/ risk reduction, STI prevention, STI screening, HIV medication adherence, peer services, HIV testing/ counseling/ risk reduction for partner, and talking to partners about status. Some categories, such as STI screening and peer service received a relatively high "I did not receive information" score from participants. B. Walsh stated that conversations could be happening about these things, but they are just not understood by the client. He encouraged all Ryan White Lead Agencies to thoroughly examine their regional results to evaluate trends. Lastly, survey participants had the opportunity to request additional information about the follow services: housing services, partner/ family violence, harm reduction/ clean syringes, legal services, reproductive health services, health insurance enrollment, re-entry/ employment, support groups, peer services, hepatitis/ STI screenings, and HIV medication adherence. Of these, housing services, legal services, and support groups had the highest interest scores.

In conclusion, B. Walsh reported that results and comments were mostly favorable. Any unfavorable comments were forwarded to Regional Lead Agencies to be address. Additionally, B. Walsh noted that a new non-IHIPC committee has been formed to evaluate the effective of the survey and give recommendations about its content. The committee will be working to formulate questions that allow for a better understanding of satisfaction/ dissatisfaction and how those ideas can be applied to better service delivery.

Q&A:

- Q: J. Erdman asked- What percentage of all clients participated in the survey? Also, there seems to be an over-representation of older clients. This factor might skew survey results as older clients may be become comfortable with their routine services.
- A: B. Walsh responded: In regards to mostly older clients taking the survey, we understand that this could skew results. Working on strategies for more outreach and responses from newly diagnosed individuals can be addressed by the Survey Committee. In regards to the percentage of clients that took the survey: There are roughly 13,000 clients in the Program (clients can participate in Care only, Medication/ Premium assistance (ADAP) only, or a combination of both programs). All clients were sent an invitation to participate in the survey. As indicated on some of the trends slides, the response rate has drastically decreased since 2015. This decrease began when the survey transitioned from paper only to electronic only. To combat this issue, all lead agencies have been provided funds to purchase tablets or computers to allow client to electronically take survey throughout the year. We are hoping that this will increase the number of surveys that are submitted in coming years.
- Q: N. Holmes asked: In the future, will the survey include other gender options like gender non-conforming, gender queer, etc.?
- A: B. Walsh responded: Yes, there will be expansion with new options under gender identity. The Survey Committee will also address this.
- Q: M. Maginn asked: How many client are in ADAP only?
- A: B. Walsh responded: Approximately 9000-10000 clients are served by ADAP annually. Some clients access both ADAP and care services.

11:35 am: IDOC HIV Care Telemedicine Program/Q&A, Discussion, Input

Brian Drummond, University of IL IDOC Telemedicine Program Social Work Coordinator

**NHAS Goal 1, Goal 2, Goal 3, Goal 4, Steps of the HIV Care Continuum: All*

B. Drummond presented on the University of Illinois Chicago (UIC)/ Illinois Department of Corrections (IDOC) Telemedicine Program. First, the telemedicine process was introduced to meeting participants. It was noted that B. Drummond and his team serve all HIV-positive individuals in IDOC facilities through the use of state of the art audio and video equipment. At each appointment, an Infectious Disease Physician, Pharmacist, Social Worker (B. Drummond), the client, and a facility nurse communicate through telemedicine equipment. Special tools, such as examination cameras and electronic stethoscopes, can be used to facilitate the process. Currently, the UIC team serves approximately 750 HIV –positive patients and serves approximately 20 Hepatitis C clients per month (clients can be either HIV-negative or HIV-positive). Psychiatric services can also be accessed through the program. In addition to attending and conducting telemedicine visits with client, duties of the UIC team include monitoring drug interactions, following lab results, and discussing obstacles to medication adherence with clients. The program also follows up with clients after release to ensure that clients are being connected to HIV care services.

B. Drummond continued by noting that all inmates are given an HIV test upon intake into the IDOC system. Annually, approximately 100 people are newly diagnosed with HIV during this effort. For newly and previously diagnosed individuals, several challenges exist that may affect medication adherence: resistance, allergic/ drug interacts, stigma/ homophobia/ transphobia, medication dispensing disclosure (HIV medication might be given when other inmates are present), newness of routine as some newly diagnosed individuals have never taken daily medication, immune system issues (may have vomiting/ diarrhea/other related issues in front of other inmates), mental health issues/ depression, behavioral issues/ misplaced anger, and lack of trust in the health care system. In order to address each of these challenges in a way that is unique to the client, motivational interviewing is often practiced during telemedicine visits. When inmates are preparing for release (up to one year in advance), discussions about the client's next steps, medial needs, case management, and access to other community resources occur. Strategies to address challenges that may affect post-release functioning such as intellectual disability, deficits in adaptive function, re-entry for aged individuals after long sentences, and other unique barriers are discussed. Before release, the Program collects all client contact information for follow up (can be updated through access to IDOC's parolee tracking system), collect medical records (labs, proof of diagnosis, telemedicine notes from physician and social worker), and have clients sign a release that allows their information to be sent to Illinois HIV Care Connect for quick linkage into case management. Two to four weeks after release, the Program follows up with the client by phone, and other tracking methods are in place to ensure that client referrals are fulfilled.

Approximately 200-250 HIV positive individuals are released from IDOC. From January- June 2018, 114 had been released, and 99 were engaged in care. 15 parolees had been lost to follow up due to an unexpected immediate releases earlier this year. During the presentation, B. Drummond also demonstrated how the programs goals, objectives, and outcomes are directly related to NHAS.

Q&A

- Q: C. Wade asked: How is IDOC Telemedicine adapting to or engaging in the Getting to Zero plan or strategy? For example, addressing viral suppression, PrEP, condom distribution, partner services, and linkage to care for transitioning/ discharged clients.
- A: B. Drummond responded: Through the post-release model, many of these strategies, like PrEP, family planning, access to condoms/ condom use, and partner services are discussed during the linkage to care process. Collaboration with entities that offer correctional case management helps clients access these services after release.
- Q: C. Wade asked: Have relationships improved with follow up from IDOC and CBOs/ ASOs?
- A: B. Drummond responded: Yes, there has been improvement. In order to continue improving, some work needs to be done with training prison employees (specifically nurses) about follow up with CBOs and ASOs upon release. With high rates of staff turnover, it is sometime difficult to fully engage them.

Important Addendum: Although this was not mentioned during the webinar, B. Drumond asked that the following statement be included in the meeting minutes: " It should be noted that 99% of patients who receive treatment from UIC Telemedicine are virologically suppressed upon their release from prison and receive a 30 day supply of ARV meds prior to their release, thus supporting the "Getting to Ground Zero" movement."

12:10 pm: Recap Discussion of Today's Meeting

J. Nuss concluded the meeting by reminding participants of how each presentation is relevant to the Integrated Plan and Integrated Planning Group processes. The Prevention Work Plan and Gap Analysis presentations focused on prevention efforts, but also referred to Care when discussing Prevention for Positives and how the current HIV epidemic in Illinois helps guide planning processes. The Ryan White Satisfaction Survey presentation focused on Care and allows for examination of which services are working well and how they can be improved as client satisfaction ultimately relates back to viral suppression and overall health of clients. The UIC/ IDOC Telemedicine presentation's work with HIV and HCV clients was also related to Care and allows participants to understand how this special population is served while in IDOC facilities. J. Nuss then welcomed any comments, questions or continued discussion:

- C: J. Erdman commented: I appreciated Curt's presentation and the great work that providers have done to address gaps in prevention for MSM of Color!

12:20 pm: Adjourn – With no requests for Public Comment and no items on the parking lot, the meeting was formally adjourned at 12: 20pm.

**Planning Group presentations/discussions are centered on IHIPC functions/processes, the goals/indicators of the National HIV/AIDS Strategy (NHAS), and/or the steps of the HIV Care Continuum.*

**NHAS Goals*

Goal 1 (Reduce New HIV Infections),
Goal 2 (Improve Access to HIV Care and Health Outcomes for PLWH),
Goal 3(Reduce HIV-Related Health Disparities);
Goal 4(Achieve a More Coordinated National response to the HIV Epidemic)

** Steps of the HIV Care Continuum:*

Linkage to Care
Engagement in Care
Retention in Care
Antiretroviral Therapy
Viral Suppression